Health Care Spending Benchmark Subcommittee
Monday, May 7, 2018
1 p.m. to 3 pm
DHSS Herman Holloway Campus—Chapel
1901 North DuPont Highway, New Castle, DE

Advisory Subcommittee Members Present:

- Secretary Kara Odom Walker (Chair)
- Tim Constantine
- Tom Corrigan
- Ryan Forman
- Nick Moriello
- Tom Brown
- James Gill
- Rich Heffron
- Faith Rentz
- Steve Groff
- Regina Mitchell
- David Cutler

Advisory Subcommittee Members Absent:

- Nancy Fan (or designee)

State Staff Present:

- Steven Costantino, Director of Health Care Reform and Financing, DHSS
- Molly Magarik, Deputy Secretary, DHSS

Primary Consultants Present:

- Michael Bailit, President, Bailit Health
- Dianne Heffron, Principal, Mercer

I. Welcome and introductions (Secretary Walker)

a. The Secretary thanked the Subcommittee members for their participation and reinforced that the purpose of the benchmarks is to increase transparency and dialogue on health care spending, and not to create a spending cap or penalty or to limit health care.

II. Recap of the 4/16 Advisory Group Meeting (Michael Bailit)

a. The Advisory Group last met on April 16 and the Subcommittee recommendations were discussed. The Advisory Group was generally supportive of the Subcommittee's recommendations.
b. The Subcommittee was reminded of its charge and informed that the focus of this meeting will be on economic indices.
c. The following question was raised:
    i. The S&P health care index for Delaware showed a negative cost increase in the State. Has the group talked about this?
    Response: No, but this can be discussed during this meeting.

III. Methodology for Defining Benchmarks (Michael Bailit)

a. The Subcommittee was asked "How should the target growth rate be set?" The Advisory Group had an initial conversation on this question at its April 16 meeting.
b. There are a number of decisions to make on this question including, will the benchmark be: 1. tied to one or more indices of economic growth, inflation or another economic indicator(s); 2. adjusted (i.e., inflated or deflated by a certain number of percentage points); 3. using forecasted rates, historical rates or a blend of each; and 4. based on a multi-year approach (averaging or weighting years) or a single-year approach. The Advisory Group was asked to think about these questions further and to come prepared to discuss them during its next meeting.
c. Approaches used in other states were reviewed and include: 1. Massachusetts' use of Potential Gross State Product (PSGP); 2. Washington's use of Gross State Product (GSP); and 3. Maine's use of a Consumer Price Index (CPI)-linked methodology.
d. Massachusetts has set its cost growth benchmark based on the PGSP. First, Massachusetts assumed that output per worker would grow at the same rate as the U.S., but adjusted for projected change in the size of the Massachusetts workforce. It determined that projected GSP (unadjusted for inflation) would be 1.6%, using out-year forecasted rates (which are more stable than the near-term forecasted rates). Second, it looked at the long-run forecast of inflation, again using
   out-year forecasted rates. It determined that projected inflation
   would be 2%. Thus potential Real GSP (1.6%) + Inflation (2%) = 3.6%
e. Washington does not have a health care spending benchmark, but it does measure health care spending relative to actual GSP.
f. Maine developed a voluntary growth target in which accountable care organizations would commit to keeping annual risk-adjusted, aggregate per-member per-month growth to the target recommended by the Maine Health Management Coalition's Healthcare Cost Workgroup. In Year 1, the target was set at the Consumer Price Index for urban consumers (CPI-U) for medical care. Over the next four years, the target was set between CPI-U for medical care and the CPI-U less food and energy, gradually trending down in Year 5 to general CPI-U less food and energy plus 25% of the difference between the two indices
g. The following questions were raised on the state methodology examples:
    i. In Massachusetts, is real GSP adjusted for inflation?
       Response: The nominal estimates include inflation; the real estimates do not include inflation.
    ii. In Massachusetts, why is 0.5% "shaved off" the rate?
       Response: This was intended as a temporary reduction to motivate reduction in health care waste.
    iii. In the Massachusetts model, is the benchmark risk adjusted for underlying membership?
       Response: The benchmark measures a per capita trend and population adjustments are built into it. There is no separate health risk adjustment at the state level.
    iv. Washington has an all-payer claims database. Is it recommended that Delaware continue to use the Delaware Health Information Network (DHIN) for data needs for the benchmark?

Response: The DHIN does not have the necessary commercial insurer data, so in the short term the DHIN is likely not a data source, but hopefully in the long term.

v. How difficult is it to build data capacity in the short term?
Response: There is currently no statutory requirement that insurers report information to the DHIN so it is not a viable option in the short term.

h. Recommended criteria for the benchmark methodology includes: 1. Providing a predictable target; 2. Adjusting for the effects of changes in inflation; 3. Relying on independent, objective data sources; and 4. Accounting for significant unexpected events (e.g., Sovaldi).

i. The following comment was raised on recommended criteria:
    i. The Affordable Care Act tax on insurers has been suspended, but will resume next year, which will impact costs.
    Response: This example might fit the definition of a significant event.

j. Generally, if the health care spending benchmark is tied to economic growth, then the benchmark would imply that health care should not grow faster than the economy.

k. Measures of economic growth include:
    i. State Gross Domestic Product: the total value of goods produced and services provided in the state during a defined time period.
    ii. Personal Income Growth: the total income received by, or on behalf of, all persons from all sources: wages, income derived from owning homes, businesses, from the ownership of financial assets (except realized and unrealized financial gains and losses), government sources (e.g., Social Security benefits) and employer benefits. Wages and salaries account for about half of U.S. personal income. States track personal income growth as a measure of a state's economic trends, as state revenue depends on personal income as does spending on government assistance programs.

l. The Subcommittee reviewed and discussed past rates of economic growth in Delaware, and past and projected rates of economic growth for the U.S. In general, historical growth rates are "choppy" and there is not a lot of stability. Income growth is also volatile.

m. The following questions were raised on measures of economic growth:
    i. Will the benchmark be a number or per capita number?
    Response: The comparison from year to year will be on per capita basis.
    ii. Massachusetts assumed 30% waste in spending. Has any study been done on this in Delaware?
    Response: The 30% estimate is a general number and not specific to Massachusetts. This estimate has been cited in the "Choosing Wisely" campaign and it would be difficult to determine state-level performance.

n. The following questions and comments were raised on tying the benchmark to economic growth:
    i. Delaware has a low-growth working age population and a growing retiree population. Are there models that blend indices together and that could take these factors into consideration?
    Response: It is an option to do a hybrid index, which could include consideration of demographic changes.
    ii. The most important criterion is that the benchmark methodology provide a predictable target.
    iii. The "big picture" question is "where should we be" and it is unclear how this fits in with this discussion. Is this part of the charge?

Response: It is not part of the charge and a difficult question to answer. The health care spending benchmark is an incremental strategy to at least slow spending growth. Consideration of what spending should be, with all waste removed, could be considered subsequently.

iv. Has the group thought about hiring an economist?
Response: David Cutler is the economist advising the Advisory Group and the State.

v. Value-based payment initiatives are looking at historical trend cost. Historical trend has been 7%. Should the benchmark instead consider a trend minus a percentage?
Response: That is an option, but the proposed methods do not require annual negotiations and are easier to apply.

vi. Economic growth should be a component and its recommended that a hybrid option be used.

vii. Forecasted data should be used.

viii. It is recommended that the method should be what is easiest to measure and the least volatile.

ix. Would income growth be negatively impacted by retiree growth?

x. **Response:** Yes, but the same is true with GSP. The biggest difference between GSP and personal income is the treatment of unrealized capital gains (e.g., capital gains are not included in personal income, but are included in GSP). There is focus on GSP as a measure of state economic growth because it measures all production, not just income.

xi. The benchmark is going to be a rate of somewhere between 2.5% and 4%. State economic growth is the best approach. Past performance gives a more solid indicator of where the state has been and is more accurate.
Response: Future forecasts leverage past rates, so they're not that different.

o. Information on who/which entities develop future forecasts and how they develop them was requested.

p. Generally, if the health care spending benchmark is tied to inflation, the benchmark would imply that health care should not grow faster than the average rise in consumer-paid prices. The CPI is an index of the variation in prices paid by typical consumers for retail goods and other items. Specifically for food, clothing, shelter, fuel, transportation, medical care, prescription drugs and other goods and services that people buy for day-to-day living.

q. There are four options for measuring CPI.
    i. **CPI-Urban, All Items (CPI-U):** represents spending for approximately 94% of the total U.S. population of urban or metropolitan areas, including professionals, self-employed, low-income, unemployed and retired. Not included are farmers, people in the Armed Forces and those in institutions (e.g., prisons, mental hospitals).
    ii. **CPI-U Less Food and Energy:** removes food and energy prices from the calculation, as these prices are typically the most volatile.
    iii. **CPI-U Less Medical Care:** removes medical care from the calculation, since the health care spending benchmark is focused on medical care.
    iv. **CPI-U Medical Care:** represents spending only on medical care services (professional, hospital and health insurance) and medical care commodities (Rx, DME) only.

r. The following comment was raised on CPI:

i. In looking at the percentage change in CPI, there isn't a big difference when medical care is removed (CPI-U Less Medical Care).

s. The Subcommittee was asked the following questions:
   i. Is tying health care spending to consumer price growth — past or projected — a good idea?
   ii. What would be the rationale for making the linkage to CPI?
   iii. If it is a good idea, which of these options is preferable and why?
      1. CPI-Urban (CPI-U), all items?
      2. CPI-U, less food and energy?
      3. CPI-U, less medical care?
      4. CPI medical care?
   iv. If it is a good idea, which of these options is preferable and why?
      1. Average of past performance?
      2. Projection of future performance?

t. The Subcommittee reviewed some of the pros and cons of various economic indicators.

u. The following questions and comments were raised on tying the benchmark to various economic indicators:
   i. A large operating cost in hospital systems is staff and there is some control of personnel quantity. Another price factor that hospitals do not have control over is pharmaceuticals.
   ii. In Massachusetts, how was the economic indicator determined?
   Response: Massachusetts did a custom calculation of PGSP.
   iii. Will the choice of economic indicator matter?
   Response: There is significant variation if basing the benchmark on historical performance depending upon the time horizon. This is due, in large part, to the effects of the Great Recession.
   iv. Gross state product is the recommended economic indicator.

v. The Department of Finance has identified two proxy indicators that may estimate the demand for health care services: 1. population growth (total and 65+); and health care employment. The Department has suggested that these two indicators not be used alone, but potentially in conjunction with measures of economic growth or inflation. These are not necessarily a recommendation, but ideas for consideration.

w. The following questions and comments were raised on proxy indicators:
   i. Health care employment is not relevant for a variety of reasons.
   ii. A goal should be to better understand what is driving health care costs (e.g., it may be the case that the aging population is a big factor). Another consideration is that people do no pay the costs—they only see the copay.

x. The Department of Finance suggested that a weighted mix of measures could be used to more fully capture inflation drivers, cost drivers and population growth. The Delaware Economic and Financial Advisory Council's Committee on Budgets has been looking at the following multi-component index as a means of forecasting state budget growth: 1/2 personal income growth and 1/2 (consumer price index + population growth).

y. The Department of Finance has noted that, specific to the health care benchmark, the following weighted mix of measures could be a possibility: 1/4 personal income growth, 1/4 on consumer price index, 1/4 on population growth for individuals 65+, and 1/4 on growth in health care employment.

z. The Subcommittee recommended that gross state product with projected values be used with an adjustment for population growth of those over 65.

aa. The Subcommittee was asked the following additional questions:
    i. Will the economic indicator(s) be adjusted (inflated or deflated (+/-) by a certain number of percentage points)?
    ii. Will it/they be based on a multi-year approach (averaging or weighting years) or a single-year approach?

bb. The following was discussed in response to these questions:
    i. Does payer mix have an effect on the cost (e.g., Medicare, commercial)? **Response:** Conceptually yes, payers will impact level of spending. In Massachusetts, prices are reasonably similar over time.
    ii. The spending reduction goal should be deflated by a "significant amount" (e.g., more than 0.5%).
    iii. A hybrid approach is recommended (e.g., GSP and CPI Less Medical Costs).
    iv. Access and quality should be considered. Access is a driver of costs; if residents cannot access primary care, then that impacts costs.
    v. Is benchmark built around GEAR?
    vi. GEAR has recommended developing the benchmark.
    vii. The costs areas for highest impact should be prioritized.

IV. Public comment (interested parties)

a. No public comments were submitted.

V. Wrap-up and next steps (Secretary Walker)

a. There are two remaining Advisory Group meetings: May 22, 2018 and June 6, 2018**.**
b. After completing discussion of the health care spending and quality benchmark methodologies, the Advisory Group will turn to two final topics:
    i. Any changes that may need to be made to the scope and composition of the Health Care Commission for it to implement the benchmark setting and evaluation process, and
    ii. Proposed methods for analyzing and reporting on variations in health care delivery and cost in Delaware.
c. A report with the Advisory Group's feedback will be presented to the Secretary by the end of June.
d. A question was asked about whether that will be shared with the Advisory Group. **Response:** The report will not include deliberations from the June meeting. A plan is still being worked out if there are material changes from the last meeting.